

WEST VIRGINIA CODE: §5-16-9

§5-16-9. Authorization to execute contracts for group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, group life and accidental death insurance, and other accidental death insurance; mandated benefits; limitations; awarding of contracts; reinsurance; certificates for covered employees; discontinuance of contracts.

(a) The director is hereby given exclusive authorization to execute such contract or contracts as are necessary to carry out the provisions of this article and to provide the plan or plans of group hospital and surgical insurance coverage, group major medical insurance coverage, group prescription drug insurance coverage, and group life and accidental death insurance coverage selected in accordance with the provisions of this article, such contract or contracts to be executed with one or more agencies, corporations, insurance companies, or service organizations licensed to sell group hospital and surgical insurance, group major medical insurance, group prescription drug insurance, and group life and accidental death insurance in this state.

(b) The group hospital or surgical insurance coverage and group major medical insurance coverage herein provided shall include coverages and benefits for x-ray and laboratory services in connection with mammogram and pap smears when performed for cancer screening or diagnostic services and annual checkups for prostate cancer in men age 50 and over. Such benefits shall include, but not be limited to, the following:

- (1) Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force;
- (2) A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age 18 and over;
- (3) A test for the human papilloma virus (HPV) for women age 18 or over, when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists for women age 18 and over;
- (4) A checkup for prostate cancer annually for men age 50 or over; and
- (5) Annual screening for kidney disease as determined to be medically necessary by a physician using any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing as recommended by the National Kidney Foundation.

(6) Coverage for general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed healthcare individuals in conjunction with dental care if the covered person is:

(A) Seven years of age or younger or is developmentally disabled and is either an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the individual and for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) A child who is 12 years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

(7) (A) A policy, plan, or contract that is issued or renewed on or after January 1, 2019, and that is subject to this section, shall provide coverage, through the age of 20, for amino acid-based formula for the treatment of severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the following conditions, if diagnosed as related to the disorder by a physician licensed to practice in this state pursuant to either §30-3-1 et seq. or §30-14-1 et seq. of this code:

(i) Immunoglobulin E and Nonimmunoglobulin E-medicated allergies to multiple food proteins;

(ii) Severe food protein-induced enterocolitis syndrome;

(iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

(iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract (short bowel).

(B) The coverage required by §15-16-9(b)(7)(A) of this code shall include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary, regardless of methodology of delivery.

(C) For purposes of this subdivision, "medically necessary foods" or "medical foods" shall mean prescription amino acid-based elemental formulas obtained through a pharmacy: Provided, That these foods are specifically designated and manufactured for the treatment of severe allergic conditions or short bowel.

(D) The provisions of this subdivision shall not apply to persons with an intolerance for

lactose or soy.

(c) The group life and accidental death insurance herein provided shall be in the amount of \$10,000 for every employee. The amount of the group life and accidental death insurance to which an employee would otherwise be entitled shall be reduced to \$5,000 upon such employee attaining age 65.

(d) All of the insurance coverage to be provided for under this article may be included in one or more similar contracts issued by the same or different carriers.

(e) The provisions of §5A-3-1 et seq. of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers, who may wish to offer plans for the insurance coverage desired: Provided, That the director shall negotiate and contract directly with health care providers and other entities, organizations and vendors in order to secure competitive premiums, prices, and other financial advantages. The director shall deal directly with insurers or health care providers and other entities, organizations, and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder's fee, or any combination thereof, shall be paid to any individual or agent; but this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent, within this state, to service the companies' contracts awarded under the provisions of this article. Commissions reasonably related to actual service rendered for the agent or agents may be paid by the underwriting company or companies: Provided, however, That in no event shall payment be made to any agent or agents when no actual services are rendered or performed. The director shall award the contract or contracts on a competitive basis. In awarding the contract or contracts the director shall take into account the experience of the offering agency, corporation, insurance company, or service organization in the group hospital and surgical insurance field, group major medical insurance field, group prescription drug field, and group life and accidental death insurance field, and its facilities for the handling of claims. In evaluating these factors, the director may employ the services of impartial, professional insurance analysts or actuaries, or both. Any contract executed by the director with a selected carrier shall be a contract to govern all eligible employees subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance carrier from soliciting employees covered hereunder to purchase additional hospital and surgical, major medical, or life and accidental death insurance coverage.

(f) The director may authorize the carrier with whom a primary contract is executed to reinsure portions of the contract with other carriers which elect to be a reinsurer and who are legally qualified to enter into a reinsurance agreement under the laws of this state.

(g) Each employee who is covered under any contract or contracts shall receive a statement

of benefits to which the employee, his or her spouse and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to whom claims shall be submitted and a summary of the provisions of the contract or contracts as they affect the employee, his or her spouse and his or her dependents.

(h) The director may at the end of any contract period discontinue any contract or contracts it has executed with any carrier and replace the same with a contract or contracts with any other carrier or carriers meeting the requirements of this article.

(i) The director shall provide by contract or contracts entered into under the provisions of this article the cost for coverage of children's immunization services from birth through age 16 years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis-b, hemophilia influenzae-b, and whooping cough. Additional immunizations may be required by the Commissioner of the Bureau for Public Health for public health purposes. Any contract entered into to cover these services shall require that all costs associated with immunization, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration be exempt from any deductible, per visit charge and/or copayment provisions which may be in force in these policies or contracts. This section does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions.

(j) The director shall include language in all contracts for pharmacy benefits management, as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly to the agency for all pharmacy claims the amount paid to the pharmacy provider per claim, including, but not limited to, the following:

- (1) The cost of drug reimbursement;
- (2) Dispensing fees;
- (3) Copayments; and
- (4) The amount charged to the agency for each claim by the pharmacy benefit manager.

In the event there is a difference between these amounts for any claim, the pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the pharmacy benefit manager shall be kept secure, and notwithstanding any other provision of this code to the contrary, the agency shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the agency. All data and information provided by the pharmacy benefit manager shall be considered proprietary and confidential and exempt from disclosure under the West Virginia Freedom of Information Act pursuant to §29B-1-4(a)(1) of this code. Only those agency employees involved in collecting, securing, and analyzing the data for the purpose of preparing the report provided for herein shall have access to the proprietary

data. The director shall, using aggregated, non-proprietary data only, report at least quarterly to the Joint Committee on Government and Finance on the implementation of this subsection and its impact on program expenditures, including any difference or spread between the amount paid by pharmacy benefit managers to the pharmacy providers and the amount charged to the agency for each claim by the pharmacy benefit manager.

(k) If the information required herein is not provided, the agency may terminate the contract with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline the pharmacy benefit manager as provided in §33-51-8(e) of this code.